6–12 months. All patients received counseling on the risks of delaying dialysis. Patients who accepted dialysis immediately were classed 'elective starters' ($n = 151$) and those who declined were 'initial refusers' ($n = 82$).

Of the initial refusers, 45 received emergency hemodialysis after developing symptomatic uremia or a uremic crisis; 39 of these were subsequently established on maintenance peritoneal dialysis ('late starters'). One-year all-cause mortality was significantly higher among initial refusers than among elective starters (18.3% vs 6.6%; $P = 0.004$), as was cardiovascular mortality (9.8% vs 2.6%; $P = 0.014$). In a model adjusted for age, sex, GFR and diabetic status, initial refusers were three times more likely than elective starters to die. Compared with elective starters, late starters were more likely to develop peritonitis, be hospitalized or require a blood transfusion, and they had lower serum albumin levels and protein catabolic rates during their first year of dialysis.

The authors conclude that delaying initiation of dialysis until after uremic symptoms develop is likely to compromise patient outcomes.

Original article Tang SCW *et al.* (2007) Delaying initiation of dialysis till symptomatic uraemia—is it too late? *Nephrol Dial Transplant* [doi: 10.1093/ndt/gfm109]

Statin use is associated with a decreased risk of sepsis in patients on dialysis

Sepsis is a major cause of death in patients on dialysis. Studies have indicated that statins, which are widely used to treat and prevent cardiovascular disease, might also have utility in preventing and reducing the severity of sepsis. As part of the recent prospective, multicenter CHOICE study, investigators determined whether statin use was associated with a decrease in the incidence of sepsis in patients with chronic kidney disease on dialysis.

Between October 1995 and June 1998, the study enrolled 1,041 patients aged >17 years who had started maintenance outpatient dialysis in the previous 3 months. Patients were followed up until January 2005. The primary outcome was hospitalization for sepsis.

At baseline, 14% of patients were taking statins. During follow-up, there were 303 hospitalizations for sepsis in 165 patients (after a mean of 3.4 years). Statin users were 63% less likely to be hospitalized for sepsis than were nonusers (crude sepsis incidence rates 41/1,000 patient-years vs 110/1,000 patient-years, respectively; $P<0.001$). Even after adjustment for demographic characteristics, dialysis modality, comorbidities and laboratory values, the risk of hospitalization for sepsis was 62% lower in statin users. When patients with a history of sepsis were excluded from the multivariate analyses, statin users were still 60% less likely to be hospitalized for sepsis. In a subcohort analysis of 214 patients matched according to their propensity to be prescribed a statin, statin users were 76% less likely to be hospitalized for sepsis than were nonusers.

Original article Gupta R *et al.* (2007) Statin use and hospitalization for sepsis in patients with chronic kidney disease. *JAMA* **297:** 1455–1464

Aspirin lowers *S. aureus* infection risk in hemodialysis patients with tunneled catheters

Tunneled catheter use is a risk factor for *Staphylococcus aureus* infections in dialysis patients. Sedlacek *et al.* investigated whether aspirin—which has antistaphylococcal effects—reduced the incidence of *S. aureus* bacteremia in hemodialysis patients with tunneled catheters.

The study was a retrospective analysis of 872 patients who had undergone hemodialysis using tunneled catheters at two US dialysis units during a 10-year period. Overall, 1,853 tunneled catheters were placed and 4,722 blood cultures were performed. Aspirin use was determined by examination of medication lists, notes and discharge summaries.

Overall bacteremia incidence was 7.2 cases/100 patient-catheter-months; incidence of *S. aureus* bacteremia was 2.1 cases/100 patient-catheter-months. The rate of catheter-associated *S. aureus* bacteremia was significantly lower in aspirin users than in those not taking aspirin (0.17 events/patient-catheter-year vs 0.34 events/patient-catheter-year; $P = 0.003$). Incidences of other types of bacteremia were not significantly different between aspirin users and nonusers. Among aspirin users, *S. aureus* infection rate was lower in patients taking a 325 g daily dose than in those receiving a 81 mg dose. According to two statistical models, aspirin lowered the risk of a first episode of *S. aureus*